

## REPORT - HIPAA 835 to AFRSc mapped fields only

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
		<b>Health Care Claim Payment/Advice</b>						DDE to AFRS for payment. Need to store fields from the 837-claim to populate the 835-RA.	Processing Logic
	<b>ST</b>	<b>Transaction Set Header</b>		<b>R</b>					
	ST 01	Transaction Set Identifier Code	ID3	R				Hard code "835"	Translation
	ST 02	Transaction Set Control Number	AN9	R				Compute; Generate from 1 increment by 1 for each TS in a functional group	Translation
	<b>BPR</b>	<b>Financial Information</b>		<b>R</b>				BALANCING: (sum of all CLP04-claim payments) minus (sum of PLB prov adj) must equal BPR02-payment amount	Processing Logic
	BPR01	Transaction Handling Code	ID2	R				Hard code; "P"=pre-notify to test; else "I"	Translation
	BPR02	Total Actual Provider Payment Amount	R18	R				Sum of all CLP04-claim payments	HIPAA Required
	BPR03	Credit or Debit Flag Code	ID1	R				Hard code "C"	Translation
	BPR04	Payment Method Code	ID3	R				Get payment method from AFRS warrant register response	HIPAA Required
	BPR05	Payment Format Code	ID10	S				BPR05+ are required if using EFT	HIPAA Required
	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	ID2	S				Hard code "01" for US banks	Translation
	BPR07	Sender DFI Identifier	AN12	S				Hard code payor's BankID	Translation
	BPR08	Account Number Qualifier	ID3	S				Hard code "DA"	Translation
	BPR09	Sender Bank Account Number	AN35	S				Hard code payor's Account Number	Translation

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	BPR10	Payer Identifier	AN10	S				Hard code "1"+payor's Fed TaxID	Translation
	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	ID2	S				Hard code "01" for US banks	Translation
	BPR14	Account Number Qualifier	ID3	S				if "C", use "DA"; if "S", use "SG"	Translation
	BPR16	Check Issue or EFT Effective Date	DT8	R				Get warrant date from AFRS warrant register response	HIPAA Required
	<b>TRN</b>	<b>Reassociation Trace Number</b>		<b>R</b>				Need to store ACH ID number (warrant number)	HIPAA Required
	TRN01	Trace Type Code	ID2	R				Hard code "1"	Translation
	TRN02	Check or EFT Trace Number	AN30	R				Get warrant # from AFRS warrant register response; if BPR04="CHK" use check number; if BPR04="EFT" use ACH number	HIPAA Required
	TRN03	Payer Identifier	AN10	R				Same as BPR10, in case different payers use the same TRN02 numbers	Translation
	<b>CUR</b>	<b>Foreign Currency Information</b>		<b>S</b>					
	<b>REF</b>	<b>Receiver Identification</b>		<b>S</b>				Req'd if 835 sent to anyone other than payee	HIPAA Required
	REF01	Reference Identification Qualifier	ID3	R				"EV"-receiver ID	Translation
	REF02	Receiver Identifier	AN30	R				Get from 837 NM109-Submitter Identifier	Match Back
	<b>REF</b>	<b>Version Identification</b>		<b>S</b>					
	REF01	Reference Identification Qualifier	ID3	R				Hard code "F2"	Translation
	REF02	Version Identification Code	AN30	R				Hard code; version number of TARGET system	Translation
	<b>DTM</b>	<b>Production Date</b>		<b>S</b>					

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<b>1000A</b>	<b>N 1</b>	<b>Payer Identification</b>		<b>R</b>					
<b>1000A</b>	<b>N 1</b>	<b>Payer Identification</b>		<b>R</b>					
1000A	N 101	Entity Identifier Code	ID3	R				Hard code "PR"	Translation
1000A	N 102	Payer Name	AN60	S				Hard code payor's name: "WA DSHS DASA"	Translation
1000A	N 103	Identification Code Qualifier	ID2	S				Hard code "XV" when PlanID used; else "FI"-federal tax ID	Translation
1000A	N 104	Payer Identifier	AN80	S				Hard code payor's National PlanID when used; else federal tax ID	HIPAA Required
<b>1000A</b>	<b>N 3</b>	<b>Payer Address</b>		<b>R</b>					
1000A	N 301	Payer Address Line	AN55	R				Hard code payor's address	Translation
<b>1000A</b>	<b>N 4</b>	<b>Payer City, State, ZIP Code</b>		<b>R</b>					
1000A	N 401	Payer City Name	AN30	R				Hard code payor's address	Translation
1000A	N 402	Payer State Code	ID2	R				Hard code payor's address	Translation
1000A	N 403	Payer Postal Zone or ZIP Code	ID15	R				Hard code payor's address	Translation
<b>1000A</b>	<b>REF</b>	<b>Additional Payer Identification</b>		<b>S</b>					
<b>1000A</b>	<b>PER</b>	<b>Payer Contact Information</b>		<b>S</b>					
1000A	PER01	Contact Function Code	ID2	R				Hard code "CX"	Translation
1000A	PER02	Payer Contact Name	AN60	S				Hard code payor's adjudication contact for electronic remittance advice	Translation
1000A	PER04	Payer Contact Communication Number	AN80	S				Hard code contact phone #	Translation
<b>1000B</b>	<b>N 1</b>	<b>Payee Identification</b>		<b>R</b>					
<b>1000B</b>	<b>N 1</b>	<b>Payee Identification</b>		<b>R</b>					

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1000B	N 101	Entity Identifier Code	ID3	R				Hard code "PE"	Translation
1000B	N 103	Identification Code Qualifier	ID2	R				Hard code "F1"-TaxID, until "XX"-NPI used.	Translation
1000B	N 104	Payee Identification Code	AN80	R				Either TaxID or NPI is required	Match Back
<b>1000B</b>	<b>N 3</b>	<b>Payee Address</b>		<b>S</b>					
<b>1000B</b>	<b>N 4</b>	<b>Payee City, State, ZIP Code</b>		<b>S</b>					
<b>1000B</b>	<b>REF</b>	<b>Payee Additional Identification</b>		<b>S</b>					
1000B	REF01	Reference Identification Qualifier	ID3	R				hard code "PQ"-local ID for payee	Translation
1000B	REF02	Additional Payee Identifier	AN30	R	AFRS-screen-E	VENNO	PIC X(10).		
1000B	REF02	Additional Payee Identifier	AN30	R	AFRS-screen-E	VENSUFF	PIC X(2).		
<b>2000</b>	<b>LX</b>	<b>Header Number</b>		<b>S</b>					
<b>2000</b>	<b>LX</b>	<b>Header Number</b>		<b>S</b>					
2000	LX 01	Assigned Number	N06	R				Required if > 1 claim per transaction.	System Questions
<b>2000</b>	<b>TS3</b>	<b>Provider Summary Information</b>		<b>S</b>					
<b>2000</b>	<b>TS2</b>	<b>Provider Supplemental Summary Information</b>		<b>S</b>					
<b>2100</b>	<b>CLP</b>	<b>Claim Payment Information</b>		<b>R</b>					
<b>2100</b>	<b>CLP</b>	<b>Claim Payment Information</b>		<b>R</b>				BALANCING: CLP03-claim charge minus (sum of all CAS service line adjustments) must equal CLP04-claim payment	Processing Logic
2100	CLP01	Patient Control Number	AN38	R				Provider's ID for patient, as received on 837-claim CLM01	Match Back

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2100	CLP02	Claim Status Code	ID2	R				map codes; default to "3"-processed as tertiary	Map Codes
2100	CLP03	Total Claim Charge Amount	R18	R	AFRS-screen-E	AMT	PIC 9(11)V99.	Sum of all SVC02 if > 1	HIPAA Required
2100	CLP04	Claim Payment Amount	R18	R	AFRS-screen-E	AMT	PIC 9(11)V99.	Sum of all SVC03 of > 1	HIPAA Required
2100	CLP06	Claim Filing Indicator Code	ID2	R				Hard code "14"-exclusive provider org.	HIPAA Required
<b>2100</b>	<b>CAS</b>	<b>Claim Adjustment</b>		<b>S</b>					
<b>2100</b>	<b>NM1</b>	<b>Patient Name</b>		<b>R</b>					
2100	NM101	Entity Identifier Code	ID3	R				Hard code "QC"	Translation
2100	NM102	Entity Type Qualifier	ID1	R				Hard code "1"	Translation
2100	NM103	Patient Last Name	AN35	R				Store and return from 837	Match Back
2100	NM104	Patient First Name	AN25	R				Store and return from 837	Match Back
2100	NM105	Patient Middle Name	AN25	S				Store and return from 837	Match Back
2100	NM108	Identification Code Qualifier	ID2	S				Store and return from 837	Match Back
2100	NM109	Patient Identifier	AN80	S				Store and return from 837	Match Back
<b>2100</b>	<b>NM1</b>	<b>Insured Name</b>		<b>S</b>					
<b>2100</b>	<b>NM1</b>	<b>Corrected Patient/Insured Name</b>		<b>S</b>				Required if patient name is corrected from 837 to 835	System Questions
<b>2100</b>	<b>NM1</b>	<b>Service Provider Name</b>		<b>S</b>					
2100	NM108	Identification Code Qualifier	ID2	R				Hard code "MC"-Medicaid ID or "XX"-NPII	Translation
<b>2100</b>	<b>NM1</b>	<b>Crossover Carrier Name</b>		<b>S</b>					
<b>2100</b>	<b>NM1</b>	<b>Corrected Priority Payer Name</b>		<b>S</b>					

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2100	MIA	Inpatient Adjudication Information		S					
2100	MOA	Outpatient Adjudication Information		S					
2100	REF	Other Claim Related Identification		S					
2100	REF	Rendering Provider Identification		S					
2100	DTM	Claim Date		S				required if not all service lines have dates	System Questions
2100	DTM01	Date Time Qualifier	ID3	R				if range, "232"=Claim Statement Period Start; "233"=Claim Statement Period End	Translation
2100	DTM02	Claim Date	DT8	R	AFRS-screen-E	DOC-MMDDYY .	PIC X(6).		
2100	PER	Claim Contact Information		S					
2100	AMT	Claim Supplemental Information		S					
2100	QTY	Claim Supplemental Information Quantity		S					
2110	SVC	Service Payment Information		S				Support max 999 service lines per claim	HIPAA Required
2110	SVC	Service Payment Information		S				BALANCING: SVC02-submitted service charge minus (the sum of all CAS adjustments) must equal SVC03-service payment	Policy Issues
2110	SVC01	Product or Service ID Qualifier	ID2	R				Store 837 SV101-1, or "NU" for paper UB	Match Back
2110	SVC01	Procedure Code	AN48	R				Required if adjudicated at service line level.	Match Back
2110	SVC01	Procedure Modifier	AN2	S				professional only: Store all modifiers from 837 SV101	Match Back

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2110	SVC02	Line Item Charge Amount	R18	R				Required if adjudicated at service line level.	System Questions
2110	SVC03	Line Item Provider Payment Amount	R18	R				Required if adjudicated at service line level.	System Questions
<b>2110</b>	<b>DTM</b>	<b>Service Date</b>		<b>S</b>				Required if there is no claim date.	System Questions
2110	DTM01	Date Time Qualifier	ID3	R				Hard code; "472" for one date service; "150" for begin of date range; "151" for end of date range	Translation
<b>2110</b>	<b>CAS</b>	<b>Service Adjustment</b>		<b>S</b>					
<b>2110</b>	<b>REF</b>	<b>Service Identification</b>		<b>S</b>				"6R" required if sent on 837.	HIPAA Required
2110	REF01	Reference Identification Qualifier	ID3	R				Hard code; "6R"=Provider's line item number; "G1"=prior authorization number	Translation
2110	REF02	Provider Identifier	AN30	R				we also need PA# at service line level	Processing Logic
<b>2110</b>	<b>REF</b>	<b>Rendering Provider Information</b>		<b>S</b>					
<b>2110</b>	<b>AMT</b>	<b>Service Supplemental Amount</b>		<b>S</b>					
<b>2110</b>	<b>QTY</b>	<b>Service Supplemental Quantity</b>		<b>S</b>					
<b>2110</b>	<b>LQ</b>	<b>Health Care Remark Codes</b>		<b>S</b>					
<b>2110</b>	<b>PLB</b>	<b>Provider Adjustment</b>		<b>S</b>					
<b>2110</b>	<b>SE</b>	<b>Transaction Set Trailer</b>		<b>R</b>					
2110	SE 01	Transaction Segment Count	N010	R				Compute, number of included segments, including ST, SE	Translation
2110	SE 02	Transaction Set Control Number	AN9	R				Same as ST02	Translation

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### Comment Type Legend:

Case Management = "Nice to Have" fields for case reviewers.

Electronic COB = If we do electronic COB, these fields will be needed.

HIPAA Questions = Questions about interpreting the HIPAA Implementation Guides.

HIPAA Required = Required fields in HIPAA that don't seem to be in the legacy system.

Map Codes = Need to crosswalk local codes to standard codes.

Match Back = Fields received on an incoming transaction that must be returned in the response.

Nice to Have = Optional fields that are useful for other reasons.

Policy Issues = Decisions to be made by system experts.

Processing Logic = Logic that needs to be built into either the front end or MMIS.

System Questions = Questions about the legacy systems.

Translation = Only use to program translations.

### Column Heading Legend:

"DT" = Data Type

### COBOL Data Types Legend:

X(n) - Character data with length of n bytes

9(n) - Integer data with length of n bytes

S9(n) - Signed integer data with length of n bytes

9(n)V99 or 9(n)V9(2) - Numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

S9(n)V99 or S9(n)V9(2) - Signed numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

### HIPAA Data Types Legend:

ANn - Free text with length of n bytes

IDn - Coded value with length of n bytes

Nn - Numeric data with length of n bytes

Rn - Real data with length of n bytes

DT8 - Date expressed as CCYYMMDD

TM8 - Time expressed as HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds ((00-99)